# OUTPATIENT/AMBULATORY SERVICES

Effective Date: 11-07-2020

## I. PURPOSE

The purpose is to define and provide guidance as to what is allowable for the Outpatient and Ambulatory Medical Care category of service, in accordance with HRSA standards.

## II. DEFINITION

Provision of Outpatient and Ambulatory Medical Care, defined as the provision of professional diagnostic and therapeutic services rendered by a licensed physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting (not a hospital, hospital emergency room, or any other type of inpatient treatment center), consistent with Public Health Service (PHS) guidelines and including access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. Outpatient medical settings may include clinics, medical offices, mobile vans, using telehealth technology, and urgent care facilities for HIV-related visits.

Allowable services include:

- Diagnostic testing
- Early intervention and risk assessment,
- Preventive care and screening
- Practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions
- Prescribing and managing of medication therapy
- Education and counseling on health issues
- Well-baby care
- Continuing care and management of chronic conditions
- Referral to and provision of HIV-related specialty care (includes all medical subspecialties even ophthalmic and optometric services)
- Treatment adherence

As part of Outpatient and Ambulatory Medical Care, provision of laboratory tests integral to the treatment of HIV infection and related complications.

## III. PROGRAM GUIDANCE

Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category

whereas Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category.

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Alabama Department of Health (ADPH) Service Standards for people living with HIV, including the following:

## PERFORMANCE MEASURE

Documentation of the following:

- Care is provided by health care professionals certified in their jurisdictions to prescribe medications in an outpatient setting such as a clinic, medical office, or mobile van
- Only allowable services are provided
- Services are provided as part of the treatment of HIV infection
- Specialty medical care relates to HIV infection and/or conditions arising from the use of HIV medications resulting in side effects
- Services are consistent with HHS Guidelines
- Service is not being provided in an emergency room, hospital or any other type of inpatient treatment center

Appendix A: HRSA/HAB National Monitoring Standards, and HRSA/HAB Core Performance Measures Portfolio and Core Measures links below. These sources provide supportive information for CQM program expectations for the recipient and provider subrecipients. HRSA HAB Core Performance Measures Portfolio: https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio

HRSA HAB Core Performance Measures link: https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/coremeasures.pdf

## PROVIDER/SUBGRANTEE RESPONSIBILITY

- Ensure that client medical records document services provided, the dates and frequency of services provided, that service are for the treatment of HIV infection
- Include clinician notes in patient records that are signed by the licensed provider of services
- Maintain professional certifications and licensure documents and make them available to the grantee on request

## EXCEPTIONS AND EXCLUSIONS

May not include:

- Complementary or alternative treatments including chiropractic care, massage therapy, hypnotherapy, and acupuncture.
- Inpatient medical services.

- Emergency room services.
- Pharmacist consultations.
- Non-HIV related visits to urgent care facilities

| *PCN 16-02: Outpatient/Ambulatory Health Services are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting...Allowable activities include: a) medical history taking; physical examination; c) diagnostic testing, including laboratory testing; d) behavior risk assessment, counseling & referral; e) preventive care and screening; f) pediatric developmental assessment; g) prescription & management of medication therapy; h) treatment adherence; i) education & counseling on health and prevention issues; j) referral to and provision of specialty care related to HIV diagnosis. (HRSA/HAB PCN 16-02)* | |
|---|---|
| **Standard** | **Measure** |
| **Documentation** | |
| 1.1) All OAHS provided is documented in client record. | 1.1) Documentation of OAHS is in client's record signed and dated. |
| 2.1) When a third-party payer provides service, the subrecipient must maintain a client record. At a min minimum, the payer's record and the dental emergencies record must maintain:<br>• Referral;<br>• Initial assessment;<br>• Individualized treatment plan, including treatment modality and frequency and quantity of treatments;<br>• Documentation of all contacts & dates of service;<br>• Reassessment of treatment plan to include monitoring and assessment of client progress;<br>• Referrals and follow-ups; and<br>• Discharge plan.<br>All reports must be signed and dated. | 2.1) Signed, dated reports located in the client's record. |
| **Assessment/Service Plan/Provision of Services** | |
| 3.1) A comprehensive initial medical history and physical examination is performed within 30 days of client contact with provider.<br>Additional dimensions of the comprehensive history and assessment include:<br>• Oral health assessment<br>• Psychosocial/Mental health assessment<br>• Substance use screening and assessment<br>• Nutritional assessment. | 3.1) Documentation of comprehensive medical history and physical assessment in client's record signed and dated by provider. |

| | |
|---|---|
| 3.2) Initial Physical Examination is completed within 30 days of client contact with the provider. | 3.2) Documentation of initial physical assessment in client's record signed and dated by provider. |
| 3.3) Medication history assesses which includes:<br>a. drug allergies<br>b. current medications<br>c. drug/substance abuse | 3.3) Documentation of medical history in client's record signed and dated by provider. |
| 3.4) Initial laboratory results or orders are completed as a component of the initial assessment. | 3.4) Documentation of initial labs in client's record signed and dated by provider. |
| 3.5) A medical treatment plan is developed in collaboration with the client. The client is offered a copy of the medical plan. | 3.5) Documentation of the medical care plan in the client's record, signed and dated by provider and client. |
| 3.6) Medical care plan is updated every six months or more frequently as needed | 3.6) Documentation in the client record that the medical care plan is updated at least every six months signed and dated by medical care provider |
| **Follow Up Visits** | |
| A.1) Provision of the following services in accordance with HHS HIV Treatment Guidelines as part of the treatment of HIV infection:[vi]<br>• Diagnostic testing, including laboratory testing<br>• Early intervention and risk assessment<br>• Preventive care and screening<br>• Physical examination<br>• Medical history taking<br>• Diagnosis, treatment, and management of physical and behavioral health conditions<br>• Behavioral risk assessment, subsequent counseling and referral<br>• Prescription and management of medication therapy<br>• Access to antiretroviral therapies, including combination antiretroviral treatment, and prophylaxis and treatment of opportunistic infections<br>• Treatment Adherence<br>• Education and counseling on health and prevention issues<br>• Pediatric developmental assessment/Well-baby care | A.1) Documentation of services in client's record signed and dated by provider. |

| | |
|---|---|
| • Referral to and provision of HIV- related specialty care related to HIV diagnosis.<br>*Note:* Care must be provided in outpatient setting, such as clinic, medical office or mobile van. Only allowable services can be provided. Specialty medical care relates to HIV infection and/or conditions arising from the use of HIV medications resulting in side effects. | |
| A.2) History, q. 6 months, or p.r.n. | A.2) Documentation of services in client's record signed and dated by provider. |
| A.3) Physical Exam, q. 6 months, or p.r.n. | A.3) Documentation of services in client's record signed and dated by provider. |
| A.4) Clients seen at least twice in the past 12 months by a medical provider | A.4) Documentation of services in client's record signed and dated by provider. |
| A.5) Laboratory Testing, q. 6 months, or p.r.n | A.5) Documentation of services in client's record signed and dated by provider. |
| A6) Medication history reviewed at each visit which includes new:<br>a) Drug allergies<br>b) Current medications<br>c) Drug/substance abuse<br>d) Treatment adherence | A.6) Documentation of services in client's record signed and dated by provider. |
| A.7) Oral health assessment, referral, and annual/ routine dental care to be completed | A.7) Documentation of services in client's record signed and dated by provider. |
| A.8) Nutritional assessment or referral to be completed | A.8) Documentation of services in client's record signed and dated by provider. |
| A.9) Current (in last year) ophthalmology exam or referral if CD4 < 100 or hx of DM or HTN to be completed | A.9) Documentation of services in client's record signed and dated by provider. |
| A.10) Breast exam to be completed, where applicable (females) | A.10) Documentation of current breast exam, where applicable in the client's record? (females) |
| A.11) Follow up from referrals documented | A.11) Is there documentation of follow up from referrals in the client's record? |
| B.1) CD4, q. 12 months, or p.r.n. | B.1) Documentation of services in client's record signed and dated by provider. |

| | |
|---|---|
| B.2) Viral Load (HIV/RNA), q. 6 months, or p.r.n. | B.2) Documentation of services in client's record signed and dated by provider. |
| B.3) CBC, q. 12 months, or p.r.n. | B.3) Documentation of services in client's record signed and dated by provider. |
| B.4) Chemistry Panel, q. 6 months, or p.r.n. | B.4) Documentation of services in client's record signed and dated by provider. |
| B.5) Toxoplasmosis Antibody Titer at baseline if CD4< 100. | B.5) Documentation of services in client's record signed and dated by provider. |
| B.6) Resistance Genotyping /Phenotyping, p.r.n.<br>a) Genotypic resistance testing (baseline; treatment failure)<br>b) Phenotypic resistance testing (known virologic failure; known complex drug resistance pattern(s) | B.6) Documentation of services in client's record signed and dated by provider. |
| B.7) Lipid Panel (annually) | B.7) Documentation of services in client's record signed and dated by provider. |
| B.8) Urinalysis (baseline & annually or if on TDF-tenofovir) | B.8) Documentation of services in client's record signed and dated by provider. |
| B.9) Liver/Hepatic Panel (baseline; q. 6 months, annually) | B.9) Documentation of services in client's record signed and dated by provider. |
| B.10) Glucose (if not in Chem Panel; baseline& annually); Hemoglobin A1C q 6 months or p.r.n. | B.10) Documentation of services in client's record signed and dated by provider. |
| B.11) Hepatitis A serology at baseline<br>If negative, patient referred for Immunization | B.11) Documentation of services in client's record signed and dated by provider. |
| B.12) Hepatitis B serology at baseline and p.r.n. ongoing risk factor behavior<br>If negative patient referred for Immunization | B.12) Documentation of services in client's record signed and dated by provider. |
| B.13) Hepatitis C serology at baseline and p.r.n. ongoing risk factor behavior | B.13) Documentation of services in client's record signed and dated by provider. |
| B.14) Hepatitis C serology at baseline and p.r.n. ongoing risk factor behavior<br>If positive, patient evaluated and /or referred | B.14) Documentation of services in client's record signed and dated by provider. |

| | |
|---|---|
| B.15) STD risk assessment evaluated at each visit (e.g. Syphilis, Gonorrhea, Chlamydia) | B.15) Documentation of services in client's record signed and dated by provider. |
| B.16) Asked about STD symptoms at each visit | B.16) Documentation of services in client's record signed and dated by provider. |
| B.17) VDRL/ RPR initially and q12 months with reports on the record where applicable | B.17) Documentation of services in client's record signed and dated by provider. |
| B.18) TB risk factors reviewed annually and p.r.n, | B.18) Documentation of services in client's record signed and dated by provider. |
| B.19) TB testing (PPD or interferon-based testing) at initial presentation, repeated if baseline CD4+ was < 200 but has risen to > 200, and p.r.n based on risk factor review? | B.19) Documentation of services in client's record signed and dated by provider. |
| B.20) Pap Smear, twice in first year and then annually thereafter –Are dates and results in the record? | B.20) Documentation of services in client's record signed and dated by provider. |
| B.21) Mammogram annually > 50 years with dates and results in the record? | B.21) Documentation of services in client's record signed and dated by provider. |
| B.22) Chest x-ray at baseline for patients with positive TB testing or prn for underlying lung disease – dates and results in the record? | B.22) Documentation of services in client's record signed and dated by provider. |
| B.23) Special Studies-other testing based on individual needs. Dates and results in the record (as applicable) | B.23) Documentation of services in client's record signed and dated by provider. |
| B.24) Pre-Conceptual Discussion and Counseling for all women of childbearing age at baseline and routinely thereafter. | B.24) Documentation of services in client's record signed and dated by provider. |
| C.1) Current medications documented in the client's record | C.1) Are all current medications documented in the client's record? |
| C.2) Medication adherence assessment done at each visit | C.2) Is medication adherence assessment with documentation done at each visit? |
| C.3) Medication side effects assessed and documented | C.3) Documentation of services in client's record signed and dated by provider. |
| C.4) When applicable, document client's AIDS diagnosis status | C.4) Does the client have a documented AIDS diagnosis? |
| C.5) Document if HAART been offered to the client | C.5) Has HAART been offered to the client, when applicable? |

| | |
|---|---|
| C.6) Document if the client currently on HAART | C.6) Documentation of services in client's record signed and dated by provider. |
| C.7) Ensure HAART are consistent with current PHS Guidelines? | C.7) Is HAART consistent with current PHS Guidelines? |
| C.8) Client on PCP prophylaxis if CD4<200 | C.8) Documentation in client's record signed and dated by provider. |
| C.9) Client on Toxoplasmosis prophylaxis if CD4<100 | C.9) Documentation in client's record signed and dated by provider. |
| C.10) Client on MAC prophylaxis if CD4<50 | C.10) Documentation in client's record signed and dated by provider. |
| E.1) An appropriate outcome based medical plan of treatment developed with the client | E.1) Documentation of an appropriate outcome based medical plan of treatment developed with the client and present in the client's record. |
| E.2) Client Education documented in the client's record? | E.2) Documentation of services in client's record signed and dated by provider. |
| E.3) Progress notes present, current, legible, signed and dated in the client's record | E.3) Are progress notes present, current, legible, signed and dated in the client's record? |
| E.4) Prevention and Risk factor reduction/ Counseling message provided at each visit? | E.4) Documentation of Prevention and Risk factor reduction/ Counseling message at each visit? in client's record signed and dated by provider. |
| F.1) Influenza (annually) | F.1) Documentation of services in client's record signed and dated by provider. |
| F.2) Pneumovax | F.2) Documentation of services in client's record signed and dated by provider. |
| F.3) Prevnar 13 | F.3) Documentation of services in client's record signed and dated by provider. |
| F.4) Hepatitis A series- if serology is negative- is series completed? | F.4) Documentation of services in client's record signed and dated by provider. |
| F.5) Hepatitis B series –if serology is negative –is series completed? | F.5) Documentation of services in client's record signed and dated by provider. |

| | |
|---|---|
| F.6) Tetanus/Diphtheria (or Tdap x 1) (every/ ten years) | F.6) Documentation of services in client's record signed and dated by provider. |
| F.7) Others | F.7) Documentation of services in client's record signed and dated by provider. |
| G.1) Is there adequate documentation of care provision in the client's record? | G.1) Documentation of services in client's record signed and dated by provider. |
| G.2) Are there an initial history, physical, and laboratory reports in the client's record? | G.2) Documentation of services in client's record signed and dated by provider. |
| G.3) Do all progress notes reflect health status, response to treatment and services provided to client? | G.3) Documentation of services in client's record signed and dated by provider. |
| G.4) Are there current laboratory reports in the client's record? | G.4) Documentation of services in client's record signed and dated by provider. |
| G.5) Are there current medication records, ADAP and non-ADAP (name of drug, dosage, time) in the client's record? | G.5) Documentation of services in client's record signed and dated by provider. |
| G.6) Is appropriate referral and follow-up documented in the client's record? | G.6) Documentation of services in client's record signed and dated by provider. |
| G.7) Is there documentation in the client's record that current standards of care for the HIV/AIDS client are practiced? If not, comment. | G.7) Documentation of services in client's record signed and dated by provider. |
| G.8) Provide laboratory tests integral to treatment of HIV infection and related complications. Tests must be:<br>• Ordered by a certified, licensed provider<br>• Consistent with medical and laboratory standards<br>• Approved by the Food and Drug Administration (FDA) and/or Certified under the Clinical Laboratory Improvement Amendments (CLIA) Program. | G.8) Documentation of laboratory tests performed in client's record, signed and dated. |
| G.9) Refer clients not following up with Outpatient Ambulatory Health Services for six (6) months to case management or patient navigator services for re-engagement in care. | G.9) Documentation of attempts to contact client and referrals in the client's record, signed and dated. |
| G.10) Refer client to HIV specialty care and/or other services as appropriate, e.g. mental health, substance abuse treatment. | G.10) Documentation of referrals made and status of outcome in client's record. |

**References:**

HRSA/HAB Ryan White HIV/AIDS Program Services: Clarifications on Eligible Individuals & Allowable Uses of Funds, Policy Clarification Notice # 16-02 (revised 10/22/18).

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards—Program Part B (April 2013), p. 23.

Public Health Service Act; Sections 2605(a)(6), 2617 (b) (7) (F), 2664 (f) (1), and 2671 (i).

Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1 infected adults and adolescents. Department of Health and Human Services (2016)

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards—Program Part B (April 2013)

# APPENDIX A: HIV/AIDS BUREAU, DIVISION OF STATE HIV/AIDS PROGRAMS NATIONAL MONITORING STANDARDS FOR RYAN WHITE PART B GRANTEES: PROGRAM – PART B

## QUALITY MANAGEMENT

**Quality Management**

National Monitoring Standards: Implement a Clinical Quality Management Program (CQM) to include: a) written QM plan; b) quality expectations for providers and services; c) method to report and track expected outcomes; d) monitoring of provider compliance with HHS treatment guidelines and Part B Program's approved Standards of Care.

| Standard | Measure |
|---|---|
| 1.1) Measure and report client health outcomes using Outpatient Ambulatory Health Services measures approved by ADPH. | 1.1) Performance measurement data on the following indicators:<br>• Percentage of people living with HIV and receiving Outpatient Ambulatory Health Services, regardless of age, supporting retention in care: ≥1 medical visit in each 6-month period of the 24-month measurement period, occurring at least 60 days apart. (Benchmark: At least 90 percent retention in care among clients receiving OAMC).<br>• Percentage of people enrolled in RW Part B-funded Program living with HIV and receiving Outpatient Ambulatory Health Services, regardless of age, who will have an HIV viral load less than 200 copies/mL at most recent HIV viral load test collected during the 12-month measurement period. (Benchmark: At least 80 percent viral suppression among clients receiving OAMC). |

HRSA HAB National Monitoring Standards link: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf